MADRAS MEDICAL COLLEGE AND

RESEARCH INSTITUTE

CHENNAI

PSYCHOLOGY CASE RECORD

Submitted to

The Tamilnadu Dr. M. G. R. Medical University

In Partial Fulfillment of the Requirements

For

DPM Final Examination

March 2010

By

Dr. CHAND PARVEEN SULTANA

INSTITUTE OF MENTAL HEALTH, KILPAUK

CHENNAI – 600 010

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BONAFIDE CERTIFICATE

This is to certify that this is a bonafide record of the work done by **Dr. Chand Parveen Sultana** in partial fulfillment of the requirement for the DPM Final Examination of the Tamilnadu Dr. M. G. R. Medical University during the period May 2008 - March 2010.

Assistant Professor of Psychology

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I thank the Director, Institute of Mental Health, Chennai - 600 010, who has given his kind permission to interview the patients for preparing this case record.

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I would also like to thank the patients and their family members who cooperated for undergoing the tests and gave the necessary details required.

INDEX

CASE I

Name	:	Mr. N
Age	:	40 yrs
Sex	:	male
Occupation	:	Unemployed
Religion	:	Hindu
Education	:	XII standard
Socio economic	:	MSES
Informants	:	elder sister, mother, nephew
Information	:	Reliable, Adequate and inconsistent

REASONS FOR CONSULTATION:

1. Preoccupied
2. Not communicating well
3. Laughing and talking to self
4. Sleep disturbance
5. Poor self care
6. Abusive and assaultive

7 Years increased for 5 months

7. Disinhibited behaviour
8. Suicidal gesture

1 month

1st episode, insidious in onset, continuous

No obvious stressor, on irregular treatment

3rd psychiatric consultation.

HISTORY OF PRESENT ILLNESS:

Mr. N was reported to be normal 7 years back, he was found to be preoccupied and not communicating well with his family members. When asked about his behaviour he gave no answer.

He was found to be talking and laughing to self. When asked he said that he heard voices speaking to him and he was replying to it. Gradually his sleep decreased and he would sleep only for 3 to 4 hours at night. He did not take care of himself. He would not bath or change his clothes. This continued for 2 months after which he started to be abusive and assaultive for no reason. He did not allow any of his family members to enter into house. So he was taken to a psychiatrist, was admitted for 10 days and treated with ECT. After discharge he would discontinue medications on and off during which his symptoms would get exacerbated.5 months back after death of his father he discontinued medications. He became abusive and assaultive and did not sleep. He was taken to a psychiatrist but he refused to take medications.

During the past 1 month he became disinhibited. He was found disrobing his clothes and just kneeling in front of the wall naked. He did this on three occasions and gave no answer for this behaviour.

He also exhibited suicidal gestures on three occasions in the form of carrying kerosene and match box inside the bathroom. Hence he was brought to IMH and admitted.

No H/O sad mood, crying spells

No H/O tall claims, spending spree

No H/O thoughts being known to others or withdrawn

No H/O substance use

No H/O head injury, LOC, seizures, fever or any prolonged drug intake.

PAST HISTORY:

Diagnosed to have hypertension since three months but not on medication

No H/O any psychiatric illness in the past

No H/O diabetes, tuberculosis, asthma or IHD.

FAMILY HISTORY:

He was born of 3rd degree consaguinous marriage.6th of 8 siblings.

H/O mental illness probably psychotic in 3rd elder brother

H/O alcohol dependence in two elder brothers and paternal cousin.

PERSONAL HISTORY:

He was born out of full term normal delivery. Normal developmental milestones. Started going to school at 5 years of age. Had average scholastic performance .He did not go for any work and spent his time at home just watching television and would get angry if asked to go for work.

PREMORBID PERSONALITY:

He was introvert, shy, not responsible, preferred to be alone and had few friends. His hobbies were reading Tamil magazines. Features were suggestive of schizoid personality traits.

PHYSICAL EXAMINATION:

Conscious, ambulant

Moderately built and nourished

BP – 120/70 mm Hg.

PR-80/min.

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, nontender, No organomegaly

CNS – Clinically normal.

Fundus – normal

MENTAL STATUS EXAMINATION:

General Appearance, Behaviour and attitude: an alert ambulant male who looks appropriate for his age entered slowly into the room accompanied by his mother. Dressed in a shirt and lungi.unclean and unkempt. Gaze avoidance was present and rapport established with difficulty. Took long time to answer to questions. Partially cooperative but interested in the interview. Would get up and go away if probed about his behaviour.

Posturing was present

Psychomotor activity reduced

Speech –quantum and tone reduced, reaction time prolonged, poverty of speech present

Thought – stream reduced, form sometimes irrelevant, content revealed ideas of persecution

Perception- no abnormalities elicited

Mood –Euthymic

Affect – blunted

PRIMARY MENTAL FUNCTIONS:

Attention arousable, concentration illsustained

Oriented to time, place and person

Memory – immediate, recent and remote – intact

General fund of information – not adequate

Arithmetic ability good

Abstract thinking impaired.

Judgement to social and hypothetical situation impaired

Insight: Grade 1

INVESTIGATIONS:

Haematological investigations – Normal

ECG – normal

EEG – normal

Chest X-ray – NAD

CT Brain – normal study

PROVISIONAL DIAGNOSIS

ICD 10 1) F20-3 undifferentiated schizophrenia

2) F29 Unspecified non – organic psychosis

PSYCHOMETRY:

Mr N, an unmarried person with long duration of mental illness on irregular psychiatric treatment was assessed with following psychological tests

TESTS ADMINISTERED

1) SAPS- scale for assessment of positive symptoms
2) SANS – scale for assessment of positive symptoms
3) PANSS – positive and negative symptoms scale
4) Rorsarch ink blot test

BEHAVIOURAL OBSERVATION:

His cooperation for examination was initially poor and on successive sessions better. His attention could be arousable but concentration was slightly impaired. He talked relevantly and irrelevently also.

TEST FINDINGS:

Psychopathological testing brought out mild amount of positive symptoms in the area of referential thinking and persecutory ideas with moderate to severe amount of negative symptoms suggestive of gross psychopathology.

Rorsarch test: projective test also brought out disorganization of personality, impaired reality testing and mentation. His emotional reactions were dominated by negative type due to no colour responses. There were card rejections and stereotyped responses suggestive of definite impairement in his thinking and organization abilities.

DIAGNOSTIC: Psychopathological testing brought out mild amount of positive symptoms in the area of referential thinking and persecutory ideas with moderate to severe amount of negative symptoms with pharmacotherapy.

IMPRESSION:

With these, this patient manifested features of chronic schizophrenia with paranoid features. He needs regular psychosocial intervention in addition to stabilization of positive symptoms.

SUMMARY:

He has symptom of psychosis predominantly negative features on various tests suggesting that patient is suffering from schizophrenia – undifferentiated type.

FINAL DIAGNOSIS:

ICD-10: F 20.3 Undifferentiated schizophrenia.

MANAGEMENT:

PHARMACOLOGICAL

Patient is on

T.Risperidone 2mg

1 -0 -1

T. Lorazepam 2 mg

0 – 0 – 2

PSYCHOLOGICAL

Psycho education to the family emphasizing the importance of drug compliance

At present he is highly disturbed. So, psychological interventions are not much of help at present. However, Supportive psychotherapy and Occupational therapy is of help to divert his talks and thoughts into useful activities.

CASE II

Name	:	Mr. A
Age	:	25 yrs
Sex	:	Male
Marital status	:	Divorcee
Occupation	:	Agricultural labourer
Religion	:	Hindu
Education	:	VIII standard
Socio economic	:	LSES
Informants	:	father and patient self
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

1. Difficulty in erection - 8 years
2. Sad mood
3. Lack of interest
4. Preoccupied — 10 months
5. Sleep disturbance
6. Not going for work

2nd episode, insidious onset, continuous, following a stressor in the form of remarriage of his wife.

This is the 2nd psychiatric consultation.

HISTORY OF PRESENT ILLNESS:

Mr A was reported to be normal 8 years back when he use to work regularly and maintaining well. He use to masturbate regularly. After one year when he pushed a heavy lorry he felt that his penis has decreased in size and not able to get full erection. He continued to masturbate for the next one year during which his penis further decreased in size. He stopped to masturbate and felt guilty about his masturbatory behaviour. He frequently doubted whether he will be able to perform after marriage. These thoughts continued but he was regular to work and use to communicate well with his friends.

When patient was 22 years of age, his mother died in an accident. He was compelled by his paternal aunt to get married. He was not ready for marriage and planned to get treatment first but he was forced to marry. During the first night he felt fearful but he was able to overcome this fear and able to penetrate, perform the sexual act for a minute and ejaculate. On the third day he developed an ulcer over his penis and got cured in 7 days. He felt that was due to his masturbatory behaviour.

He felt sad and did not communicate with his family members. He was just lying down in bed and did not go for any work. His wife exhibited irritability and anger towards him because of his behaviour. After 45 days she went to her mother place. His symptoms worsened and developed sleep disturbance. He took treatment in government hospital at Madurai, his condition improved and he went for work. He discontinued treatment on his own.

After 4 months his wife asked for a divorce from his wife, to which he silently consulted. He started to develop all his symptoms again and had loss of interest, sleep disturbance, multiple somatic complaints, guilt feelings, anxiety, reduced self esteem and loss of weight.

H/O smoking beedi for past 5 years

H/O alcohol consumption for, 3 years back

No H/O suicidal ideas or attempts

No H/O tall claims, spending spree, elated mood

No H/O local injury, drug intake, sexual perversions, gender identity problems

No H/O head injury, LOC, seizures.

PAST HISTORY:

No H/O any psychiatric illness in the past

No other significant past history.

FAMILY HISTORY:

He is 2nd of the 3 siblings. Mother died 3 years back in a road traffic accident.

PERSONAL HISTORY:

Full Term normal Delivery. Developmental milestones normal. Started to go to school at 4 years of age. Good peer group relationship.

No H/O any conduct disturbance, child abuse

He use to masturbate once a week since 16 years of age.

Studied up to VIII standard but failed. Hence he started to work as a labourer in grape farms.

PREMORBID PERSONALITY:

He is an introvert and responsible person, caring towards his family. He is a anxious person. His hobbies are watching movies.

PHYSICAL EXAMINATION:

Moderately built and nourished.

General examination – No abnormality detected.

BP – 110/80 mm Hg.

PR-88/min.

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, nontender, No organomegaly

CNS – Clinically normal.

Bilateral fundus – Normal.

Local examination –penis normal in length

No external lesions, scrotum normal

Testis bilaterally palpable.

MENTAL STATUS EXAMINATION:

General appearance and behaviour and attitude: An alert ambulant male who looks appropriate for his age entered the room on his own and took the seat offered. Dressed adequately and appropriately. Clean and kempt. Fidgeting was present. He kept wriggling his fingers and moving his feet. Gaze contact made and sustained. Rapport established with initial difficulty.

Psychomotor activity increased

Speech- quantum, tone and reaction time normal

Thought – stream, form normal

Content - preoccupied with the thought about his potency and ability to perform and lead a good sexual life.

Guilt feelings regarding his masturbatory behaviour

Ideas of helplessness and worthlessness

Perception – no perceptual abnormalities

Mood – sad, guilty

Affect – depressed, appropriate, other range of emotions restricted.

PRIMARY MENTAL FUNCTIONS

Attention arousable and concentration well sustained

Oriented to time, place and person

Memory – Immediate, Recent and remote intact.

General fund of information – adequate

Arithmetic ability good

Abstract thinking – intact.

Judgement to social and hypothetical situation - Intact.

Insight – Grade IV

INVESTIGATIONS:

Haematological investigations – Within Normal Limits

Blood VDRL and HIV ELISA– Nonreactive.

ECG – Within Normal Limits

Chest X-ray – Normal.

Penile Doppler – normal penile Doppler study.

PROVISIONAL DIAGNOSIS

ICD 10 F52 Sexual dysfunction, not caused by organic disorder or disease

F52.2 Failure of genital response

F33.2 Recurrent depressive disorder, current episode severe without psychotic symptoms.

PSYCHOLOGICAL ASSESSMENT.

Mr A 25 year male was referred for psychodiagnostic assessment.

TESTS ADMINISTERED

1. Sentence completion test
2. Hamilton depression scale
3. State and trait anxiety scale
4. Dysthymia rating scale
5. Arizona sexual experience scale
6. Brief sexual function inventory

BEHAVIOURAL OBSERVATIONS:

Eye contact maintained rapport initially difficult; attention could be aroused and sustained. Patient answers relevantly and coherently. Speaks in a low tone, decreased talk output, no spontaneous talk. Patient appeared dull and depressed. He was able to comprehend instructions.

TEST RESULTS:

Test finding has shown that the patient has negative attitude about self and feels guilty about masturbatory behaviour which was projected on the sentence completion test. Anxiety inventory scale has shown a percentile of 100 on both state and trait anxiety indicating a generalized anxiety levels are present in this patient.

On HAM-D, patient has score of 34 suggestive of moderate to severe depression. Dysthymia rating scale also shows a moderate amount of depressed mood.

Arizona sexual experience scale shows there is a strong sexual drive but he is not able to have a sexual arousal and not able to have erection. Very unsatisfied in his sexual performance. Sexual function inventory shows a low on sexual drive past 30 days and he never had erection. On problem assessment it has shown that he has problem on a erection and ejaculation and is very dissatisfied in performance. There is a low in sexual drive because of his depressed mood.

IMPRESSION:

Patient with adequate cognitive function with an evidence of depression and sexual dysfunction.

SUMMARY: Patient has negative attitude about self due to erectile dysfunction and severe amount of depression.

FINAL DIAGNOSIS:

ICD 10 F52 Sexual dysfunction, not caused by organic disorder or disease

F52.2 Failure of genital response

F33.2 Recurrent depressive disorder, current episode severe without psychotic symptoms.

MANAGEMENT:

PHARMACOLOGICAL:

1) T.Imipramine 25mg

1 - 0 – 2

2) T. Lorazepam 2 mg

0 – 0 – 2

PSYCHOLOGICAL:

Cognitive behaviour therapy for his depression and correct his cognition and false belief about his erectile dysfunction.

Teaching him Masters and Johnson techniques for better sexual performance with his partner. Advice to stop smoking and alcohol.

CASE III

Name	:	Mrs. A
Age	:	70 yrs
Sex	:	Female
Marital status	:	Widow
Religion	:	Hindu
Education	:	Uneducated
Socio economic	:	LSES
Informants	:	Daughter in law
Information	:	Reliable, Inadequate and consistent

REASONS FOR CONSULTATION:

1. Forgetfulness - 6 months
2. Talking to self
3. Trying to go out of the house — 3 months
4. Sleep disturbance
5. Removing clothes at inappropriate places
6. Passing urine and motion in dress itself — 3weeks
7. Needs help for self care

4th episode, insidious onset, progressive course, no obvious precipitating factors

II psychiatric consultation

HISTORY OF PRESENT ILLNESS:

Patient was reported to be normal 6 months back. She developed memory disturbance in the form of unable to recognize distant relatives, searching for her belongings in house, repeating work which she had already completed, way finding difficulty and forgetting if she has taken food or not.

For the last 3 months she was found to be talking to self and lamenting about past incidents. She would walk restlessly inside the house, gesturing and moving her hands constantly. She tries to go out of the house and has to be forced to comeback inside. She had difficulty in initiating and maintaining sleep and would get up many times or keep talking irrelevantly.

After death anniversary of her husband she started to remove her sari and remained nude inside in the room. She did not take bath or take her food and has to be forced to do so. She passed urine and motion in dress itself and did not care about it. She did not do any household chores, did not communicate with her family members.

H/O giddiness and leg pain on and off

No H/o sad mood, suicidal ideation

No H/O drug intake, seizures, substance use

No H/O headache or symptoms suggestive of TIA

No H/O hearing voices, tall claims, spending spree

PAST HISTORY:

H/O similar episodes in 2000, January 2007, November 2007. She exhibited symptoms of irrelevant talk, decreased self care, not doing any household chores and sleep disturbance for which she took treatment from a private psychiatrist

No H/O memory disturbance in the past.

No H/O Hypertension or Diabetes Mellitus or tuberculosis

No H/O any suicidal ideation in the past

FAMILY HISTORY:

Born of non consaguinous marriage.2nd of four siblings.

Younger brother and son are alcohol dependent

No history of mental illness, suicide or absconders in the family.

PERSONAL HISTORY:

Early childhood history was not known

Worked as a agricultural labourer until 1 year back

Attained menopause 20 years back

Living with 2 sons

PREMORBID PERSONALITY:

Extrovert, responsible

Regular to work

Caring toward her children

Well adjustable and hard working

PHYSICAL EXAMINATION:

Thin built, not anaemic, not jaundiced,

Non pitting pedal oedema on left leg

Pulse – 68/min

BP – 120/80 mm Hg

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, nontender, No organomegaly

CNS – Clinically normal.

Fundus – normal

MENTAL STATUS EXAMINATION:

General Appearance and Behaviour: patient was brought into the room and made to sit on the chair. Dressed adequately, hair unkempt, gaze contact illsustained, rapport established with difficulty.

Psychomotor Activity – normal

Speech – She is not well communicable, answered in monosyllables after asking simple questions, that too repeatedly

Thought – stream decreased, poverty of thought

No delusions

Perception – no hallucinations

Mood – depressed

Affect – restricted

PRIMARY MENTAL FUNCTIONS:

Attention aroused with difficulty

Concentration not sustained

Oriented to time, place and person

Memory - immediate memory is impaired, recent and remote intact

General fund of information is adequate

Arithmetic ability poor

Abstract thinking impaired

Judgement to social situation impaired

Insight – Grade II

PROVISIONAL DIAGNOSIS:

ICD 10 1) F33.3 Recurrent depressive disorder current episode severe wit psychotic symptoms

2) F01.1 Multi infarct dementia

PSYCHOLOGICAL ASSESSMENT:

Mrs A was referred for a psychodiagnostic assessment

TESTS ADMINISTERED AND THEIR RATIONALE:

1. Mini Mental Status Examination (MMSE) – It is a screening test to identify the organic aetiology and also to assess the course of illness.
2. Dementia Rating Scale – Used to assess the severity of dementia.
3. Hamilton depression rating scale – To assess the severity of depression
4. Behavioural pathology in Alzheimer's

BEHAVIOURAL OBSERVATION:

Rapport was difficult to establish. Attention aroused with difficulty and not sustained. Eye contact illsustained. Patient appeared drowsy and was not cooperative for neuropsychology and lobar function test. Talk relevant and coherent, delayed reaction time, no spontaneous talk, speaks only in words. Poverty of speech present. Questions have to be repeated again and again. Patient was able to comprehend instructions.

TEST FINDINGS:

BGT was attempted but patient not able to do.

MMSE score 13 shows impairement

Dementia rating scale showed impairement in performance of everyday activities for 6 months, changes in eating and dressing habit and sphincter control for 3 weeks.

Personality changes in the form of purposeless hyperactivity diminished initiative and growing apathy. Concentration not adequate.

Behavioural pathology in dementia rating scale shows wandering tendency, purposeless and inappropriate activity, agitation and fear of being alone

HAM – D score 24 mild to moderate depression.

IMPRESSION:

Patient with an evidence of organic involvement probably of a dementia pattern with depression.

SUMMARY:

Patient has depression with organic involvement. But at present patient does not satisfy full criteria of dementia.

FINAL DIAGNOSIS

ICD 10 F33.3 Recurrent depressive disorder current episode severe wit psychotic symptoms.

MANAGEMENT:

<u>PHARMACOLOGICAL</u>:

1. T.Sertraline 50 mg

   1 – 1 - 0

2. Cholinesterase inhibitors are useful. They potentiate the cholinergic neurotransmitter.
3. Very low doses of antipsychotics for behavioural problems.

PSYCHOLOGICAL:

1) Family counselling to provide awareness to the family members about the guarded prognosis for this patient and the importance of rehabilitation.

2) Relatives were advised to give an understanding atmosphere to the patient and help her not to get confused.

3) Importance of proper follow-up is stressed to monitor the condition of patient and to help the family members in dealing with the patient adequately.

CASE IV

Name	:	Ms. K
Age	:	27 yrs
Sex	:	Female
Marital status	:	married
Religion	:	Hindu
Education	:	VIII
Socio economic	:	LSES
Informants	:	Self, husband
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

1) Repeated doubts about her activities
2) Frequent washing and cleaning
3) Fear for trivial matters

} 7 Years

1st episode, Insidious onset, continuous course, I psychiatric consultation.

HISTORY OF PRESENTING ILLNESS:

According to the patient, about 7 year back she started to worry about her routines and started to wash repeatedly her hands and used to take bath for long hours to keep herself clean. Though she preferred to keep herself clean, she excessively indulged in these acts only in recent times. The thoughts of cleanliness occurred repeatedly as intrusive ones in her mind and got partial satisfaction only after performing these acts. This also resulted in disturbance in her work time, resulting in absenteeism and she was left feeling helpless over this issue.

She doubted about matters like whether she had locked the door, switched off the lights and would keep checking repeatedly even though she felt it was excessive.

She also had disturbed sleep at times pondering over these issues. She felt low over this problem and consulted IMH OP, and was put on Clomipramine and Amitryptiline, following which she showed improvement.

No h/o hearing voices, suspiciousness

No h/o tall claims

No h/o head trauma or seizures

PAST HISTORY:

No significant medical or psychiatric illness.

FAMILY HISTORY:

Born of non consanguineous marriage

History of similar illness in her maternal aunty

No history of mental illness, suicide, seizures in the family

PERSONAL HISTORY:

Birth and milestones normal

Housewife

Menarche by 13 years. Regular menstrual periods

PREMORBID PERSONALITY:

Introvert, few friends, religious, perfectionist, meticulous in her activities, enjoyed stitching and watching serials.

PHYSICAL EXAMINATION:

Conscious, ambulant

BP – 120/70 mm Hg.

PR-80/min.

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, nontender, No organomegaly

CNS – Clinically normal.

Fundus – normal

MENTAL STATUS EXAMINATION:

General Appearance and Behaviour: Conscious, in touch with surroundings, well kempt, dressed adequately. Rapport was established. Gaze contact made and maintained.

Psychomotor activity – within normal limits

Talk – relevant and coherent. Quantum, rate and tone normal. Reaction time normal.

Mood – Anxious

Affect - Anxious

Thought – Form, stream normal

Content – No delusions, no referential ideas

Ideas of helplessness

Possession – Obsessions and washing compulsions.

Perception – no perceptual abnormalities

PRIMARY MENTAL FUNCTIONS:

Attention aroused, Concentration well sustained

Oriented to time, place and person

Memory – immediate, recent and remote – intact

General fund of information – adequate

Arithmetic ability good

Abstract thinking intact.

Judgement to social and hypothetical situation intact

Insight: Grade VI – True emotional insight.

PROVISIONAL DIAGNOSIS

F 42.2 Obsessive Compulsive Disorder, Mixed obsessional thoughts and acts.

PSYCHOLOGICAL ASSESSMENT:

Mrs. K provisionally diagnosed as a case of OCD is taken up for psychological assessment to assess her symptoms patterns, severity of illness and for personality.

TESTS ADMINISTERED AND THEIR RATIONALE

Eysenck Personality Questionnaire was used to assess the different dimensions of her personality.

Sentence Completion Test was used to elaborate on her attitude towards family, parents, and his interpersonal relationships.

Thematic Apperception Test, a projective test of personality used to assess her interpersonal relationship, goals and conflicts.

Rorschach test, a projective test of personality used to assess her personality structure and diagnosis.

Hamilton Anxiety Scale is used to assess the severity of anxiety

Yale Brown Obsessive Compulsive Scale: It is used to rate the severity of obsessive and compulsive symptoms.

Hamilton Rating Scale for Depression used to estimate the level of depression.

BEHAVIOURAL OBSERVATIONS DURING TESTING:

Rapport could be established easily. She came out with her problems by herself.

She was cooperative and regular to the sessions.

TEST RESULTS:

Eysenck's Personality Questionnaire Her scores indicate severe degree of neuroticism with low psychoticism and moderate extroversion.

Sentence Completion Test – She has positive feelings towards friends, superiors, teachers, marriage and women in general. She has negative feelings towards her father. She showed feelings of inferiority and high sensitivity, longing for affection from others. She is apprehensive about minor conflicts.

Thematic Apperception Test – Her stories are productive imaginative and projective of her childhood experience as a neglected child. Her parents have highly conflicting attachments which has resulted in her fears and conflicts about marriage and sex. She is also highly neurotic with fears of darkness and loneliness.

Rorschach test – Her responses reveal that she is highly imaginative which at times leads to unwanted thoughts, preoccupations and emotional reactions. She has highly disturbed personality with highly critical attitude which even amounts to paranoid ideations. She has adequate ego strength inspite of neurotic fears which favours the receptivity of psychotherapeutic interventions.

Rating Scales – reveal mixed symptoms of obsessions and compulsions with features of anxiety and a certain amount of depression due to life stressors.

SUMMARY:

She scored high on various neurotic dimensions on personality indicating that she is highly neurotic in her thoughts, feelings and reactions to the environment with which we can diagnose her as a case of mixed neurosis with obsessive symptoms.

FINAL DIAGNOSIS

F 42.2 Obsessive Compulsive Disorder, Mixed obsessional thoughts and acts.

MANAGEMENT

PHARMACOLOGICAL:

T. Fluoxetine 20 mg 1 – 1 - 0

T. Clonazepam 0.5 mg 0-0-1

PSYCHOTHERAPY:

Cognitive Behavioural Therapy to change and modify irrational thoughts.

Exposure and response prevention to manage the compulsions

Thought Stopping to manage the obsessions

As she has high dependency needs and insecurity, she was treated with supportive psychotherapy. Behaviour counselling is also undertaken. Family therapy is of utmost importance and occupational rehabilitation is also a part of therapy.

CASE V

Name	:	Mr. S
Age	:	17 yrs
Sex	:	Male
Marital Status	:	Single
Occupation	:	Unemployed
Religion	:	Hindu
Education	:	II Standard
Socio economic	:	LSES
Informants	:	Parents
Information	:	Reliable, Adequate and Consistent

REASONS FOR CONSULTATION:

Delayed milestones
Scholastic backwardness } since birth
Unable to acquire age appropriate skills

Not regular to work - 2 years

HISTORY OF PRESENT ILLNESS:

The patient was born of a non consanguineous marriage, full term normal delivery. Mother's age at time of conception was 24 years and father's age was 28 years. No history of any drug intake, fever or exanthematous eruptions in antenatal period. No antenatal checkup. No history of radiation, injury, malnutrition, vaginal bleeding. Delivery was conducted by an ayah. Cried soon after birth, breast fed after a short while. No history of neonatal seizures or difficulty in feeding. No history of jaundice. Breastfed up to 1 year. No weaning difficulties.

Milestones obtained are tabulated below.

	Milestones	Age
Motor	Head control	3-4 months
	Sitting with support	6-8 months
	Sitting without support	8 months
	Standing without support	1 year
	Walking by self	1 ½ years
	Running	3 years
Language	Babbling	4-5 months
	1 word	6 months
	2-3 words	3 years
	Named pictures	6 years
	Understood simple instructions	6 years
Personal & Social behaviour	Bladder and bowel control	6-8 years
	Dresses without assistance	8-10 years
	Playing with a group	8-10 years

The patient was educated up to 2nd standard. He discontinued studies as he found it very difficult to pass from one grade to the other. He was working as an assistant to a mason in shifting and transporting things.

PRESENT FUNCTIONING LEVEL:

The patient is able to take care of himself like bathing, dressing, eating without assistance, he goes to neighbourhood shop and could carry out simple tasks of buying things but he frequently misses calculations. He takes care in dealing with fire, crossing roads etc.

PAST HISTORY:

No overt features of psychiatric disturbances noted.

FAMILY HISTORY:

2nd of 3 siblings.

Younger sister is also having similar problems since childhood.

No history of seizures or any other illness in family.

PHYSICAL EXAMINATION:

General condition fair, well built, no pallor

Not jaundiced

Hypertelorism

Upslanting eyebrows

Depressed nasal bridge

PR – 76/min.

Blood pressure – 110/70 mm Hg.

CVS – S1, S2 heard no murmur.

RS – NVBS, no added sounds.

Abdomen – Soft, nontender, no organomegaly

NS – No FND. No neurocutaneous marker.

Bilateral Fundi – Normal.

MENTAL STATUS EXAMINATION:

General appearance and behaviour – An alert ambulant male who looks appropriate for his age entered the room on his own and took the seat offered. Dressed adequately, well kempt. Gaze contact sustained .Rapport could be established.

Talk - Quantum, Tone, Rate within normal limits. Relevant and Coherent

Mood – Euthymic

Thought – No formal thought disorder, content simple

No perceptual disturbances

PRIMARY MENTAL FUNCTIONS:

Oriented to time, place and person

Attention was aroused, but ill sustained

Concentration impaired.

Memory Immediate impaired, Recent, Remote - intact

General fund of information not adequate

Arithmetic ability – unable to do simple calculation

Judgement intact

Grade II insight

PROVISIONAL DIAGNOSIS:

ICD-10. F-70 Mental Retardation – Mild.

PSYCHOLOGICAL ASSESSMENT:

Mr. S, 17 yrs old came with history of delayed developmental milestones and poor scholastic performance. He was taken up for psychological assessment to assess his intellectual functions and social functions.

TESTS ADMINISTERED AND THEIR RATIONALE:

1. **Seguin Form Board Test:** It is a test of forms perception and is used as a test of intelligence to get the baseline intellectual abilities.

2. **Binet Kamath Test of Intelligence** (BKT): It is a test of intelligence mostly based on verbal activities and reflects global intellectual abilities.

3. **Vineland Social Maturity Scale:** It is used to assess his social maturity level.

BEHAVIOURAL OBSERVATION:

He was co-operative for testing and had adequate interest in test situation.

TEST RESULTS:

Patient was very attentive and was able to concentrate for most of tests. His psychomotor activity was within normal limits. His Gestalt functions and concept formation of size, shape, and form were adequate, has a borderline knowledge about general information, was able to do simple arithmetic and carry out simple commands without any problems. His memory span is however decreased and in Digit span test, he could not score more than 3. He has adequate knowledge about the value of currency.

He is functioning above 10 years line in his mental age as seen from Seguin form board test. In BKT his basal age was 5 years and terminal age was 11 years with mental age around 8 years (5 years + 36 months) giving rise to an IQ of around 50 placing him in mild degree of mental retardation. His social functioning is about 10 – 12 years as rated from Vineland Social maturity scale. With his parent's report he is functioning around that age in self-help, general communication and socialization, locomotion and 8 years in occupation and 12 years in dressing.

SUMMARY:

He has sub average intellectual functioning. His IQ score of 50 places him in mild MR and his social maturity and acceptability shows that this individual can be well trained to earn his livelihood to some extent to help others in family.

FINAL DIAGNOSIS:

ICD-10. F-70 Mental Retardation – Mild.

MANAGEMENT:

1. No medications are necessary as he has no psychomotor or behavioural problem.

2. He can be guided to various rehabilitation schools and training schools to teach him simple occupation with which he will be most benefited.